EXHIBIT 7
DATE 3/11/09
HB 612

March 9, 2009

Mr. Chairman, vice chairs, and members of the committee, thankyou for the opportunity to speak on HB 612. My name is Mitzi Anderson. I live in Whitefish. I represented family members on ADRT from 1991 to 1997, was NAMI-MT president from 1997 to 2000. I also served briefly on the Montana mental health council and was a member of the hospital design committee

Before I begin on the rationale for this bill I would like to emphasize several points. First, commitment statutes are not directed at people who are experiencing trauma because of life events. They are directed at people with no-fault biological brain disorders--schizophrenia, schizo-affective disorder, clinical depression, psychotic depression, and obsessive compulsive disorder. These illnesses happen, just like Alzheimer's, Parkinson's, MS. The main reason people relapse is they stop taking their medication; they don't do this out of stubborness--not realizing they are sick and that medication controls the symptoms is a symptom of these diseases. So, medication is the first line of treatment. And it must be taken regularly, just as people with diabetes, Parkinson's, MS, Alzheimers, heart disease and other chronic illnesses must take their medication regularly. Since we have about 400 people in Deere Lodge with serious mental disorders, having commited crimes while delusional, many others in our local jails, a consistant overload at MSH, as well as a very

high suicide rate, there is an obvious problem with keeping people stable.

For the rationale of this bill, we must go back to 1994, when ADRT began discussing the fact that the existing 30 day outpatient commitment then on the books was scheduled to sunset in July of 1997. ADRT members decided we needed outpatient commitment. John Lynn, now assistant director of Westrn Montana Mental Health wrote most of the bill. MAP, NAMI, AMDD, Mental Health ASSN, ADRT, MSH, Board of Visitors--all had imput. and the 1997 legislature, in its wisdom, passed the legislation with little opposition. The whole intent, then of the bill was to allow for community commitment and treatment. The need for two separate filings was eliminated, and a post-trial disposition was added so the judge could determine the level of care after the hearing. It's important to recognize that filing a petition for a commitment hearing is not a petition for commitment; it's a petition for a hearing to determine if an individual indeed is suffering from a mental disorder, needs treatment, and needs a court order in order to receive that treatment. If an individual does not meet the emergency definition he can be committed to the community mental health center. It's good legislation, but, unfortunately, neither mental health professionals or county attorneys have been applying the law. We have community commitments but mainly pon

discharge from MSH, not BEFORE they need to go. A person does not have to meet the emergency definition for a petition for hearing to be filed. But that's what family members are told over and over. Please look at the first page of my handouts. 53-21-124. Surely, if a person is imminently dangerous he will already be detained. Isn't that logical? And if he hasn't been detained, then a petition for a hearing has been filed with probable cause of serious mental disorder with the probability of deterioration and the possible threat of danger to self or others. The intent was to prevent repeated episodes of psychosis and reduce the revolving door into MSH.

HB612 merely clarifies the intent of the 1997 legislation. We have added inpatient or outpatient to the definition of commitment, added danger to self or threat of suicide to the emergency definition, changed will to MAY in the provisions in 53-21-126, and 53-21-127, because no professional can say with 100% accuracy that this person will or will not become dangerous without treatment. And finally, 53-21-151, we added teeth to the community commitment that if a person does not comply with the provisions he can be commited to an inpatient facility. Lack of teeth has long been a complaint of the outpatient commitment by law enforcement. This can't be a financial concern because without intervention and community treatment, eventual inpatient commitment is about 98% assured.

Far from being a bill to increase the numbers at MSH, HB612, if properly implemented, will reduce the numbers, eliminate the pre-commitment costs, as well as transportation costs to Warm Springs. Preventing repeated psychotic episodes most certainly improves an individual's prognosis for recovery.

53-21-124. Detention of respondent pending hearing or trial -- jail prohibited. (1) The court may not order detention of a respondent pending the hearing unless requested by the county attorney and upon the existence of probable cause for detention. Counsel must be orally notified immediately. Counsel for the respondent may then request a detention hearing, which must be held immediately.

(2) In the event of detention, the respondent must be detained in the least restrictive setting necessary to ensure the respondent's presence and ensure the safety of the respondent and of others as provided in 53-21-120.

(3) If the respondent is detained, the respondent has the right to be examined additionally by a professional person of the respondent's choice, which may not depend on the respondent's ability to pay, and the respondent must be informed of this right. Unless objection is made by counsel for the respondent, the respondent must continue to be evaluated and treated by the professional person pending the hearing.

(4) A respondent may not be detained in a jail or other correctional facility pending a hearing or trial to determine whether the respondent should be committed to a mental health facility.

History: En. 38-1305 by Sec. 5, Ch. 466, L. 1975; amd. Sec. 5, Ch. 546, L. 1977; R.C.M. 1947, 38-1305(5); amd. Sec. 2, Ch. 360, L. 1989; amd. Sec. 4, Ch. 312, L. 1991; amd. Sec. 2, Ch. 636, L. 1991; amd. Sec. 10, Ch. 342, L. 2001.